

# Health Care Financing Administration

(dollars in millions)

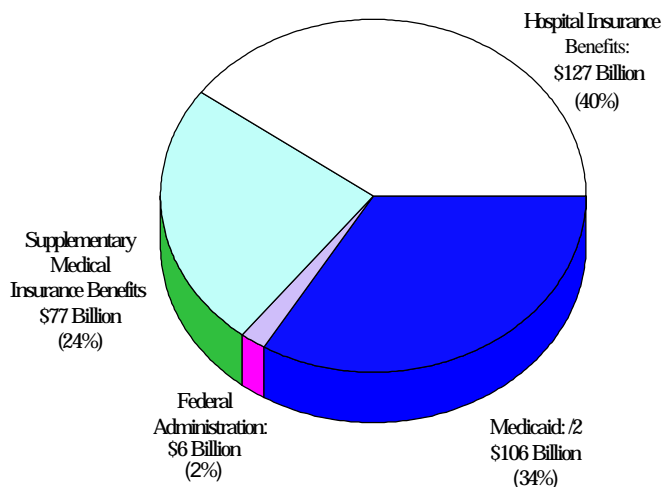
	<b>1996 Actual</b>	<b>1997 Enacted</b>	<b>1998 Request</b>	<b>Request +/- Enacted</b>
<b>Budget Authority .....</b>	261,777	295,203	310,371	15,168
<b>Outlays .....</b>	266,152	292,718	315,318	22,600
<b>FTE .....</b>	4,081	4,085	4,085	0

## Summary

The FY 1998 budget request for the Health Care Financing Administration (HCFA) is \$315.3 billion (net of offsetting receipts) for Medicare and Medicaid benefits and operating costs, an increase of \$22.6 billion over FY 1997 (see Figure 1 for the distribution of spending). Spending for the Medicare and Medicaid programs represent 84 percent of the total HHS budget for FY 1998.

The Medicare and Medicaid budget includes legislative proposals that reduce spending by \$2.9 billion in FY 1998 (\$109.5 billion over the next 5 years) and ensure that these programs can continue to provide needed health services into the next century. Medicare and Medicaid combined will pay for the health care costs of approximately 71 million elderly, disabled and economically disadvantaged Americans in FY 1998 (individuals eligible for both Medicare and Medicaid are not double counted in this figure). Slightly more than a quarter of all Americans will receive Medicare or Medicaid services in FY 1998.

## **HEALTH CARE FINANCING ADMINISTRATION FY 1998 NET OUTLAYS \$315 Billion/1**



/1 Numbers may not add due to rounding

/2 Includes benefits and State and local administration

# MEDICARE

## Summary

Medicare is a Federal health insurance program for people age 65 or older and people under age 65 who are disabled or suffer from end-stage renal disease (ESRD). In FY 1998, the program will serve approximately 39 million eligible individuals. Medicare consists of two parts:

- Part A--Hospital Insurance (HI) Pays for inpatient hospital care, some skilled nursing facility care, home health care and hospice care. The HI program is funded through the HI Trust Fund. The Trust Fund receives most of its income from the HI payroll tax (2.9 percent of payroll, split between employers and employees).
- Part B--Supplementary Medical Insurance (SMI) Pays for medically necessary physicians' services, outpatient hospital services, treatment for ESRD, laboratory services, durable medical equipment and certain other medical services and supplies. The SMI program is funded through the SMI Trust Fund. The Fund receives income primarily from two sources: a general revenue transfer and premiums paid by enrollees.

## Preserving and Modernizing Medicare

The 1998 budget preserves and modernizes Medicare, extending the solvency of the Part A Hospital Insurance Trust Fund to 2007. This budget, like the President's previous two budgets, gives beneficiaries more choices among private health plans, makes Medicare more efficient and responsive to beneficiary needs, reduces the rate of growth in provider payments,

and holds the Part B premium at 25 percent of program costs.

The President's 1998 budget builds on his 1997 budget. Last year, we wanted to ensure the solvency of the Part A Trust Fund for 10 years. According to the Chief Actuary at the Health Care Financing Administration, the Medicare policy in this budget will extend the solvency of the Trust Fund to 2007.

Last year, we wanted to restrain provider payments at a level that would continue to ensure the quality of access to care. This year, we believe that we can restrain provider payments -- particularly in the areas of managed care and hospitals -- more than we did last year, without harming quality and access.

Last year, we wanted to protect beneficiaries from major new out-of-pocket expenditures and allow them to take advantage of advances in preventive care. This year, we continue to adhere to this principle by keeping the Part B premium at 25 percent of program costs and by proposing new preventive health benefits.

The Medicare policy in our 1998 budget is similar in many ways to our policy last year. However, there are several policy changes of note, in particular with regard to payment rates for managed care, hospital outpatient prospective payment, and competitive bidding for laboratory services and durable medical equipment.

## Payment Reforms and Program Savings

- **Beneficiaries:** The 1998 budget proposes a number of changes in law that affect beneficiaries, including new benefits, Medigap protections, and proposals to increase beneficiary choice. The 1998

budget will propose extending current law that sets the Part B premium at 25 percent of program costs. This policy achieves \$10 billion in savings over five years (\$18 billion over six years). Without this policy, the Part B premium would drop below 25 percent after 1998.

- **Hospitals:** The proposals in the 1998 budget relating to hospitals will reduce the annual inflation increase, or "update," for hospitals; reduce payments for hospital capital; reform payments for graduate medical education; and implement prospective payment for outpatient departments while protecting beneficiaries from increasing charges for those services. The budget will propose to achieve \$33 billion in net savings over five years (\$46 billion over six years).

- **Managed Care:** There is substantial evidence that Medicare pays too much for managed care plans and actually loses money, on average, for every beneficiary who opts for managed care. The new policy proposals will reduce reimbursements to managed care plans by about \$34 billion over five years (\$46 billion over six years). Savings will come from three sources:

- (1) Reducing reimbursement to managed care plans from its current rate of 95 percent of fee-for-service rates to 90 percent starting in FY 2000. This accounts for \$6 billion in savings over five years (about \$8 billion over six years).
- (2) Indirect savings of \$18 billion over five years (and \$25 billion over six years) attributable to cuts in the traditional fee-for-service side of the program. Because HMO payments are based on a percentage of fee-for-service payments, projected HMO payments will be

reduced as a function of our proposed cuts in the fee-for-service side of the program.

- (3) A carve-out of medical education and uncompensated care payments from the HMO reimbursement formula to be paid directly to academic health centers and to HMOs that run their own residency programs. This aspect of the plan would reduce direct managed care payments by \$10 billion over five years (and \$13 billion over six years).
- **Physicians:** The budget will propose to save about \$7 billion over five years (about \$10 billion over six years) by establishing a single update for all physicians and replacing the current "volume performance standards" with a sustainable growth rate. This reduction is relatively small because Medicare has been fairly effective in constraining growth in reimbursement to physicians.
  - **Skilled Nursing Facilities:** The FY 1998 budget will propose to save about \$7 billion over five years (\$9 billion over six years) through the establishment of a prospective payment system. This benefit has been growing at double-digit rates, and there is a consensus that moving to prospective rates will help contain costs.
  - **Home Health Care:** Home health care has become one of the fastest growing components of the Medicare program, growing at double digit rates. To help control this growth, the budget proposes payment reforms leading to a new prospective payment system for home health. Together, these proposals will save \$14 billion over five years (\$18 billion over six years), and are included in our total

Medicare savings estimate of \$100 billion over five years (and \$138 billion over six years).

The home health program was originally designed as a post-acute care service for beneficiaries who had been hospitalized. However, over time, home health care has increasingly become a chronic care benefit not linked to hospitalization. Under the President's proposal, the first 100 home health visits following a 3-day hospitalization would be reimbursed by Part A. All other visits -- including those not following hospitalization - would be reimbursed by Part B. This provision is similar to a provision in a Medicare reform bill the House passed in 1995.

This proposal does not yield budget savings. The \$100 billion five-year savings and the \$138 billion six-year savings include no contribution from the home health reallocation. In addition, beneficiaries will not be affected by this restoration of the original policy. The policy avoids the need for excessive reductions in payments to hospitals, physicians, and other health care providers while helping to extend the solvency of the Part A Trust Fund.

- **Anti-Fraud and Abuse:** The budget proposes strong fraud and abuse provisions, including measures to eliminate fraud in home health care -- such as by ensuring that home health agencies are reimbursed based on the location of the service, not the billing office. The budget also would repeal several provisions in last year's health reform law that weakened anti-fraud enforcement. The anti-fraud initiatives in the budget will save \$9 billion over five years (\$12 billion over six years).

### **Provisions to Improve Rural Health Care**

The budget proposes to expand access to, and improve the quality of, health care in rural areas. It extends the Rural Referral Center program; allows direct Medicare reimbursement for nurse practitioners and physician assistants; improves the Sole Community Hospital program; and expands the Rural Primary Care Hospital program. Finally, the plan proposes a payment floor for managed care plans in rural areas.

### **Program Improvements that Expand Choices and Add Preventive Benefits**

The budget proposes new private plan choices - through new Preferred Provider Organizations (PPO) and Provider Sponsored Organizations (PSO) -- for beneficiaries. The budget also encourages more choices through new Medigap protections (such as new open enrollment requirements and prohibitions against the use of pre-existing condition exclusions) to increase the security of Medicare beneficiaries who wish to opt for managed care but fear they will be unable to obtain Medigap insurance if they decide to return to fee-for-service plans.

The budget also proposes new preventive health care benefits to improve the health of older Americans and reduce the incidence of disease. The plan covers colorectal screening, diabetes management, and annual mammograms without copayments. It also increases reimbursement rates for certain immunizations to ensure that seniors are protected from pneumonia, influenza, and hepatitis. The budget will also propose a new Alzheimer's respite benefit starting in 1998 to assist families of Medicare beneficiaries with Alzheimer's disease. Total beneficiary investments in the budget will cost \$13 billion over five years (\$22 billion over six years).

# MEDICARE OVERVIEW

(Beneficiaries in millions)

	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>+/-</u>
<b><u>Persons Enrolled:</u></b>				
Hospital Insurance (HI) .....	37.7	38.1	38.6	+0.5
Supplementary Medical Insurance (SMI) .....	36.0	36.5	36.9	+0.4

(Outlays in millions)<sup>1</sup>

	<u>1996 Actual</u>	<u>1997 Enacted</u>	<u>1998 Request</u>	<u>Total 1998-2002</u>
<b><u>Current Law:</u></b>				
HI Benefits .....	\$124,088	\$136,278	\$147,433	\$863,955
SMI Benefits .....	<u>67,176</u>	<u>74,937</u>	<u>82,470</u>	<u>503,519</u>
Subtotal, Medicare Benefits (includes PROs) ...	\$191,264	\$211,215	\$229,903	\$1,367,474
Health Care Fraud & Abuse Control .....	\$0	\$521	\$596	\$3,680
HCFA Admin/Research .....	2,096	1,839	1,774	8,819
SSA/Non-HCFA Admin .....	<u>894</u>	<u>897</u>	<u>1,015</u>	<u>4,980</u>
Subtotal, Admin .....	\$2,990	\$3,257	\$3,385	\$17,479
Total Outlays, Current Law .....	\$194,254	\$214,472	\$233,288	\$1,349,995
Offsetting Receipts <sup>2</sup> .....	\$-20,086	\$-20,293	\$-21,983	\$-120,646
Total Net Outlays, Current Law .....	\$174,168	\$194,179	\$211,305	\$1,229,349
<b><u>Proposed Legislation:</u></b>				
HI Savings .....	\$0	\$0	\$-19,410	\$-161,420
SMI Savings .....	0	0	14,889	69,861
Offsetting Receipts <sup>2</sup> .....	<u>0</u>	<u>0</u>	<u>211</u>	<u>-8661</u>
Total Medicare Savings .....	\$0	\$0	\$-4,310	\$-100,220
Total, Net Outlays, Proposed Law .....	\$174,168	\$194,179	\$206,995	\$1,129,129

<sup>1</sup> Numbers may not add due to rounding.

<sup>2</sup> Offsetting collections in program management and premiums collected from beneficiaries under Medicare HI and SMI.

# MEDICAID

## **Summary**

In FY 1998, Medicaid will provide grants to States for the medical care of about 38 million low-income individuals. Under current law, the Federal share of Medicaid payments is expected to reach \$104 billion in FY 1998. This is a \$5.9 billion (6 percent) increase over projected FY 1997 spending. The President will submit a comprehensive Medicaid reform package, which provides States with additional program flexibility, while preserving the guarantee of health and long-term care coverage for the most vulnerable Americans.

## **Enhancing State Flexibility**

States have considerable flexibility in structuring the Medicaid program, including determining provider payment rates, certification standards, and developing alternative health care delivery programs. In addition, waivers from various portions of the broad Federal guidelines are also available to States.

Freedom-of-choice waivers allow States to enroll beneficiaries in cost-effective systems of care, such as case management and competitive bidding arrangements. Home and community-based service waivers allow States to cover community-based care as an alternative to institutionalization.

States have also restructured eligibility and coverage under Medicaid through the use of Section 1115 demonstration waivers. Under these demonstrations, States acquire savings by incorporating managed care concepts, redirecting uncompensated care payments, and consolidating State health programs. States use these savings to expand coverage to previously uninsured populations. States are using Section 1115 waivers to reform health care by expanding

coverage without increasing the amount the Federal Government would have otherwise spent. Since 1993, this Administration has approved fifteen Section 1115 demonstrations, and is committed to working cooperatively with additional States to support innovative ideas. Delaware, Hawaii, Minnesota, Ohio, Oklahoma<sup>1</sup>, Oregon, Rhode Island, Tennessee, and Vermont are currently operating approved demonstrations, extending health care coverage to about 672,000 Americans who were otherwise not covered by health insurance. Alabama, Florida, Illinois, Kentucky, Maryland, and Massachusetts have approved waivers but have not begun operation of their demonstrations. Once fully implemented, these fifteen demonstrations could extend coverage to 2.2 million individuals, at no increased cost to the Federal Government.

## **Legislative Proposal**

The FY 1998 President's Budget would produce a net savings to Medicaid of \$9 billion from 1998-2002. The budget also makes a number of improvements to the Medicaid program, including changes to last year's welfare reform law, costing \$13 billion over the same period. These costs are more than offset by the \$22 billion in Medicaid savings from FY 1998-2002 from a combination of policies that would impose a per capita cap on spending and reduce Disproportionate Share Hospital (DSH) payments.

To allow States to better manage their Medicaid programs under the per capita cap limit, the budget would give States substantially increased flexibility such as allowing managed care without waivers. Finally, this plan retains

<sup>1</sup> Oklahoma has no expansion population in its 1115 waiver.

current nursing home quality standards and continues to protect the spouses of nursing home residents from impoverishment.

The President's Medicaid reform proposal makes other changes to give States more flexibility in managing their Medicaid programs. Changes include:

- **Coverage for Children:** The plan lets States provide continuous coverage for one year after eligibility is determined, guaranteeing more stable coverage for children and more continuity of health care services.
- **Boren Amendment:** The plan repeals the so-called "Boren amendment," eliminating Federal provider payment requirements for hospitals and nursing homes.
- **Managed care:** The plan allows States to mandate enrollment in managed care systems without going through the Federal waiver process.
- **The Working Disabled:** The plan lets States establish an income-related premium buy-in program under Medicaid for people with disabilities who work. It would let eligible Supplemental Security Income beneficiaries who earn more than certain amounts purchase Medicaid coverage by paying a premium that States would set on an income-related sliding scale.

## **Background**

Medicaid is a voluntary program, initiated and administered by the States. State expenditures for medical assistance are matched by the Federal Government using a formula based on per capita income in each State relative to the national average. Matching rates for FY 1997 are projected to range from 50 to 77 percent for medical assistance payments and

from 50 to 100 percent for administrative costs. The Federal matching rate on average is approximately 57 percent.

Historically, most individuals' eligibility for Medicaid has been based on qualifying under the cash assistance programs of Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI). With passage of the new Temporary Assistance for Needy Families (TANF) program, which replaces AFDC, Medicaid and AFDC have been de-linked. Medicaid eligibility remains tied to AFDC program rules in place on July 16, 1996. All those who qualify under the 1996 AFDC rules and most SSI recipients, commonly referred to as the "categorically eligible," are covered under State Medicaid programs. States cover some individuals not eligible under AFDC or SSI rules (e.g., people with higher incomes in institutions, low-income pregnant women and children, and aged, blind, and disabled people below the poverty line). States may also cover "medically needy" individuals. Such individuals meet the categorical eligibility criteria, but have too much income or resources to meet the financial criteria.

States are required to provide a core of 13 mandatory services to all eligible recipients. Those mandatory Medicaid services include inpatient and outpatient hospital care, health screening, diagnosis, and treatment to children, family planning, physician services, and nursing facility services to individuals over 21. States may also elect to cover any of over 30 specified optional services, which include prescription drugs, clinic services, dental, eyeglasses, and services provided in intermediate care facilities for the mentally retarded.

Medicaid covers children under the age of six and pregnant women whose family income does not exceed 133 percent of the Federal poverty level. Medicaid coverage of children aged 6 through 18, born after September 30,

1983, whose family income does not exceed 100 percent of the Federal poverty level, is being phased in. By 2002, all children under the age of 19 living below the poverty level will be eligible for Medicaid. In addition, Medicaid pays Medicare premiums and cost sharing for Medicare coverage of certain low income seniors and disabled individuals eligible for Medicare, also referred to as Qualified Medicare Beneficiaries (QMBs). The President's Medicaid reform proposal would preserve these important protections and expansions.

Federal Medicaid outlays rose dramatically from FY 1989 through FY 1992, at a 25 percent average annual rate. However, outlay growth slowed to less than 12 percent in FY 1993, followed by 8 percent growth in FY 1994. Last year in FY 1996, Medicaid growth slowed to 3.3 percent. The decline in the rate of Medicaid increases is due to many factors, including legislative changes (such as limits on provider specific taxes and donations), decreases in the projected growth of SSI caseloads, and States' efforts to control costs. The President's plan maintains these appropriate limitations.

# MEDICAID OVERVIEW

(Recipients in thousands)

	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>+/-</u>
<b><u>Beneficiaries*</u></b>				
Aged 65 and Over .....	4,460	4,517	4,575	+ 58
Blind and Disabled .....	6,809	6,966	7,034	+ 68
Needy Adults .....	7,420	7,451	7,568	+117
Needy Children .....	17,484	17,611	17,916	+305
Other .....	633	633	633	+ 0
<b>Unduplicated Total .....</b>	<b>36,805</b>	<b>37,177</b>	<b>37,727</b>	<b>+550</b>

(Outlays in millions)

	<u>1996 Actual</u>	<u>1997 Enacted</u>	<u>1998 Request</u>	<u>Total 1998-2002</u>
<b><u>Current Law:</u></b>				
Benefits .....	\$87,964	\$93,346	\$99,144	\$573,670
State and Local Administration .....	3,813	4,912	4,981	28,313
Survey and Certification .....	137	163	172	963
State Medicaid Fraud Control Units .....	<u>77</u>	<u>82</u>	<u>87</u>	<u>496</u>
<b>Total, Current Law Outlays<sup>1</sup> .....</b>	<b>\$91,990</b>	<b>\$98,503</b>	<b>\$104,384</b>	<b>\$603,442</b>
<b><u>Proposed Legislation:</u></b>				
Medicaid Savings .....	<u>\$0</u>	<u>\$39</u>	<u>\$1,417</u>	- <u>\$9,252</u>
<b>Total, Outlays<sup>2</sup> .....</b>	<b>\$91,990</b>	<b>\$98,542</b>	<b>\$105,801</b>	<b>\$594,190</b>

1 Includes Vaccine for Children Outlays.

2 Numbers may not add due to rounding.

# PROGRAM MANAGEMENT

## Summary

HCFA's FY 1998 Program Management budget request is \$1,775 million, a 2.3 percent increase over enacted FY 1997. The Program Management account provides resources for administering the Medicare and Medicaid programs. Program Management supports the following activities: Medicare Contractors, Federal Administration, Medicare Survey and Certification, and Research, Demonstrations and Evaluation.

While workloads have continued to increase every year, the Program Management budget, minus program integrity spending, has remained relatively flat, requiring HCFA to find more efficient methods to accomplish its goals as established in its strategic plan. HCFA is attempting to fulfill a significant part of this mission with the development and implementation of the Medicare Transaction System (MTS), HCFA's state-of-the-art information management initiative.

When fully implemented, MTS will consolidate the current system of 75 contractors utilizing eight shared systems, at over 30 operating sites, into one integrated information system operated by three contractors using standardized data elements. In addition to claims processing functions, MTS will merge managed care payments, beneficiary entitlement and insurance information. This initiative will achieve substantial administrative and program savings through the use of new technology, through the consolidation of Part A and Part B systems, and through standardized data. MTS will affect all aspects of Medicare, positioning HCFA to administer the program and to reengineer itself more productively for the challenging times ahead.

## Medicare Contractors

The Medicare program is administered through private organizations, usually private insurance companies, which are referred to as contractors. Contractors' responsibilities include processing claims and making benefit payments, developing management improvements called productivity investments, and responding to the needs of many customers and stakeholders, the Medicare beneficiaries and the provider community.

Due to the enactment of the Health Insurance Portability and Accountability Act of 1996, HCFA's payment safeguards program has been replaced by a new mandatory program, the Medicare Integrity Program, also operated by contractors.

Despite a growing investment in MTS and an increasing claims workload, the Medicare Contractor budget will increase by only 1.3 percent, from \$1,207.2 million in FY 1997 to \$1,223.0 million in FY 1998 due to increased efficiencies. The key contractor activities are claims processing, beneficiary and provider services, and productivity investments.

Approximately 67 percent of the FY 1998 contractor budget request, or \$824.2 million, has been designated for claims processing, a 2 percent decrease below FY 1997. HCFA's success in increasing electronic media claims submissions and in reducing the unit costs of processing claims will allow the agency to process an expected 889.1 million claims in FY 1998 within statutorily limited processing times. This workload level represents a nearly 4.3 percent increase over revised FY 1997 estimates. Beneficiary and provider services comprise approximately 20 percent of the

Medicare Contractors' FY 1998 request, or \$253 million. This amount will maintain funding for the Medicare beneficiary toll-free telephone lines, timely hearings and reconsideration, prompt responses to provider and beneficiary inquiries, provider education and training efforts. HCFA will continue its innovative use of audio response units (ARUs) for telephone inquiries, as well as its use of the telephone to conduct hearing reviews and reconsideration. These activities demonstrate HCFA's combined efforts towards more cost-effective management and a greater commitment to providing better customer service.

The budget request allocates \$145.6 million for productivity investments. Productivity investments enhance the cost-effectiveness and quality of contractor operations and are part of the long-term reform of Medicare administration. Included in this amount is \$89 million for Medicare Transaction System (MTS) implementation. HCFA estimates that MTS will achieve \$200 million in annual administrative savings and \$500 million in program savings once fully implemented. Other productivity investments include transition costs for contractors who choose not to renew their contracts with Medicare.

The Health Insurance Portability and Accountability Act of 1996 establishes the new Medicare Integrity Program (MIP) within the Hospital Insurance Trust Fund's Health Care Fraud and Abuse Control Account. Under this new program, HCFA will procure new contracts to perform Medicare program integrity activities such as medical and utilization review, coordination of benefits, audits of health care providers, developing fraud and abuse cases, and educating providers on correct Medicare procedures. In FY 1998, the Act authorizes up to \$500 million in spending for these important activities from which HCFA expects to yield \$5.8 billion back to the Trust Funds.

## **Federal Administrative Costs**

In FY 1998, the President's budget requests \$359 million for HCFA's Federal administrative costs. This request also includes a staffing level of 4,085 FTE. HCFA remains on target to meet the Department's FTE targets, thereby supporting the President's mandate on reducing the size of the Federal workforce. This funding level also includes funding to support the extensive data processing requirements for the Medicare and Medicaid program, as well as necessary maintenance and enhancement of 80 automated data systems.

This funding level allows HCFA to successfully convert its internal computer systems for the millennium change providing \$15 million for this effort. HCFA will also spend \$5 million for work associated with its annual Chief Financial Officer's Act audit. Because of the size of both the Medicare and Medicaid programs in relation to the overall federal budget, it is important that HCFA's audit be properly performed to ensure the integrity of the overall Federal audit.

## **Research, Demonstrations and Evaluation**

The FY 1998 budget requests \$45 million for the Research, Demonstrations and Evaluation program. HCFA's research program supports research and demonstration projects to develop and implement new health care financing policies and to evaluate the impact of HCFA's programs on its beneficiaries, providers, States, and our other customers and partners. Information from HCFA's research program is used by Congress, the Executive Branch, and States to improve the efficiency, quality, and effectiveness of the Medicare and Medicaid programs.

In addition to basic research, this budget fully funds the Medicare Current Beneficiary Survey at approximately \$10 million. Basic

research funds will support research and demonstration in the areas of monitoring health system performance, improving health care financing and delivery mechanisms, meeting the needs of vulnerable populations, and improving consumer choice and health status. HCFA will continue its commitment to rural health needs in FY 98 by supporting efforts for telemedicine demonstrations in rural areas.

### **Survey and Certification**

Ensuring the safety and quality of care provided by health facilities is one of HCFA's most critical responsibilities. HCFA contracts with State agencies and other organizations to inspect health facilities providing services to Medicare and Medicaid beneficiaries to ensure compliance with Federal health, safety, and program standards. HCFA's quality oversight includes initial inspections of providers who request participation in the Medicare program, annual recertification, inspections of nursing homes and home health agencies (HHAs) as required by law, investigation of beneficiary complaints, and periodic recertification surveys of other health care providers and suppliers.

In FY 1998, the President's budget requests a total of \$148 million for direct survey and certification activities and workloads. HCFA is also requesting legislation to allow States to charge initial fees to inspect new facilities requesting participation in the Medicare program. The Department's request and the legislation are necessary both to conduct initial inspections of more than 3,000 facilities expected to request Medicare participation, and to increase the frequency of annual surveys performed on non-long-term care facilities (e.g., ESRD facilities, hospices, rural health clinics). As mandated by OBRA 87, HCFA conducts recertification surveys (over 24,000) on nursing facilities and home health agencies annually.

HCFA plans to reach a recertification coverage level on non-accredited hospitals and psychiatric hospitals, hospices and other providers of 10 percent.

As part of the Health Care Quality Improvement Program, HCFA is currently placing greater emphasis on effective internal quality management systems within Medicare facilities, as well as the provider's responsibility to monitor outcomes. In FY 1998, HCFA will be retraining surveyors across the country to reinforce our focus on patient outcomes, which will result in improved quality throughout the program.

### **Clinical Laboratory Improvement Amendments of 1988**

The Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) expanded survey and certification of clinical laboratories from Medicare-participating and interstate commerce laboratories to all facilities testing human specimens for health purposes. CLIA '88 also introduced user fees for clinical laboratories to finance survey and certification activities. User fees are accounted for in the Program Management account and are available until expended for CLIA activities. The CLIA program is fully operational with about 157,000 laboratories registered with HCFA; about 60 percent of the labs are subject to routine inspection under the program.

## **HEALTH CARE INITIATIVES**

The President's health legislation package provides a number of added protections for children, working families, small businesses and States. The Administration proposes a "Healthy Working Families" program to help more than three million people (including 700,000 children) in unemployed families keep their health

insurance for up to six months. This proposal will cost \$1.7 billion in FY 1998.

The Administration also proposes a “Healty Kids” initiative in order to reduce the number of uninsured children by half by the end of FY 2000. The budget provides \$750 million in annual grants to States to build on recent State successes to develop innovative ways to provide coverage to children. The initiative also includes funds to allow States the option to extend one year of continuous Medicaid coverage to children.

The President’s budget proposal also includes \$25 million in grants to States for technical assistance to establish voluntary health insurance purchasing cooperatives to take advantage of economies of scale to which small firms normally do not have access in purchasing health insurance.

Finally, the budget package includes a proposal requiring States to assess a new user fee on health care providers for initial surveys required as a condition of participation in the Medicare program. The proposal assumes the collection of \$10 million.

### **Healthy Working Families**

- To assist families of temporarily unemployed workers, the Healthy Working Families program will provide financial assistance to unemployed workers and their families in maintaining health insurance. The new program would provide annual grants to participating States to finance up to six months of coverage for unemployed workers and their families. The program would be available to those who had employer-based coverage in their prior job, are now receiving unemployment benefits, and have an income below certain thresholds.

- An estimated 3.3 million Americans, including nearly 700,000 children, will benefit from this program. This proposal is estimated to cost \$9.8 billion for FY1998-2002.

### **Expanding Health Coverage for Children**

Nearly 10 million children --one in seven-- are uninsured in America today. Our goal is to significantly reduce this number through practical, incremental reforms. We believe this issue requires a multi-faceted strategy that involves a pragmatic series of incremental steps by both Federal and State governments as well as the private sector. These steps include:

#### Medicaid Initiatives

- Under current law, we will add an estimated 1 million children to Medicaid over the next four years under the scheduled phase-in of adolescents in families below the Federal poverty line.
- We will work with States to fulfill the promise of Medicaid for children who are already eligible under current law. An estimated 3 million children currently are entitled to Medicaid coverage but are not enrolled.
- As discussed in the Medicare section we have a legislative proposal to provide States with the option to allow continuous coverage to children, age 1 and older, for one year after eligibility is determined. This will guarantee more stable coverage for children and better continuity of health care services. This is estimated to cost \$3.7 billion for FY 1998-2002.

## Private Insurance Initiatives

- We will provide funding for States to support innovative partnerships to insure children not otherwise qualified to receive Medicaid or employer sponsored benefits. Building on the innovative steps that States have begun to take to insure children, we will provide \$750 million in annual support to States to expand insurance coverage for children in their States. This proposal is estimated to cost \$750 million per year, for a total of \$3.75 billion for FY 1998-2002.

## **Voluntary Purchasing Cooperatives**

- The President's plan would provide \$25 million a year for five years to assist States in establishing voluntary purchasing cooperatives for small employers. By forming cooperatives, small employers can bargain collectively for lower rates, and at the same time, offer a greater array of health plan choices to workers than a single small employer can usually provide. The grants will provide initial start-up capital and technical assistance for cooperatives, both of which are often hard to obtain because cooperatives are typically non-profit.

# PROGRAM MANAGEMENT OVERVIEW

(Obligations in millions)<sup>1</sup>

	<u>1996 Actual</u>	<u>1997 Enacted</u>	<u>1998 Request</u>	<u>Request +/- Enacted</u>
Medicare Contractors .....	\$1,201	\$1,207	\$1,223	+\$16
Survey and Certification .....	148	158	148	- 10
Federal Administration .....	326	326	359	+ 33
Research .....	53	44	45	+ 1
Budget Authority (Current Law) .....	\$1,728	\$1,735	\$1,775	+\$40
Medicare Integrity Program .....	\$396	\$440	\$500	+\$60
Peer Review Organizations .....	548	79	82	+\$3
CLIA .....	\$29	\$43	\$43	\$0
Program Level .....	\$2,701	\$2,254	\$2,357	+\$103
Outlays .....	\$1,728	\$1,734	\$1,775	+\$41
Legislative Proposals .....	\$0	\$0	\$2,523	+\$2,523
Healthy Working Families .....	0	0	1,738	+1,738
Grants for Health Insurance Co-op .....	0	0	25	+25
Healthy Kids State Partnership Grant .....	0	0	750	+750
Survey and Certification User Fee .....	0	0	10	+10
FTE .....	4,081	4,085	4,085	0

<sup>1</sup> Numbers may not add due to rounding.

<sup>2</sup> FY96 Actuals include fraud and abuse spending actually spent in the discretionary Medicare Contractor line under the Medicare Integrity Program for comparability purposes.

# HCFA SUMMARY

(Outlays in millions)<sup>1</sup>

	<u>1996 Actual</u>	<u>1997 Enacted</u>	<u>1998 Request</u>	<u>Request +/- Enacted</u>
<b><u>Current Law:</u></b>				
Medicare Benefits (includes PROs) .....	\$191,264	\$211,214	\$229,903	\$18,689
Medicaid Benefits (includes State admin costs)	\$91,990	\$98,503	\$104,384	\$5,881
HCFA Administration .....	\$2,096	\$1,839	\$1,774	\$-65
Other-HHS Administration .....	\$894	\$897	\$1,015	\$118
HCFAAC .....	\$0	\$521	\$596	\$75
HMO Loan Fund .....	\$-1	\$-2	\$-1	\$1
Total Outlays, Current Law .....	\$286,241	\$312,972	\$337,671	\$24,699
Offsetting Receipts <sup>2</sup> .....	\$-20,086	\$-20,293	\$-21,983	\$-1,690
Total Net Outlays, Current Law .....	\$266,155	\$292,679	\$315,688	\$23,009
<b><u>Proposed Law:</u></b>				
Medicare .....	\$0	\$0	\$-4,521	\$-4,521
Medicaid .....	0	39	1,417	1,378
Program Management .....	0	0	2,523	2,523
Offsetting Receipts <sup>2</sup> .....	<u>0</u>	<u>0</u>	<u>211</u>	<u>211</u>
Total .....	\$0	\$39	\$-370	\$-409
CLIA (Non-Add) <sub>2</sub> .....	(28)	(0)	(0)	(0)
Total Net Outlays, Proposed Law <sup>3</sup> .....	\$266,155	\$292,718	\$315,318	\$22,600
FTE .....	4081	4085	4085	0

1 Numbers may not add due to rounding.

2 Offsetting receipts include offsetting collections in program management and premiums collected from beneficiaries under Medicare HI and SMI.

3 Total net outlays equal current law outlays minus the impact of proposed legislation and offsetting receipts.